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HEALTH ADVISORY NETWORK

REPORT NUMBER ONE

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EXTENDED TREATMENT BED REVIEW

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Introduction

The Health Advisory Network (the Network) was established to provide advice and recommendations to the Minister of Health on specific matters of current concern in the provision of health services to Manitobans. The Network consists of two main components: (1) a Steering Committee; (2) a variable number of Task Forces. The Steering Committee, in consultation with the Minister, identifies areas in which Task Forces are to be set up, determines their composition and terms of reference, coordinates and rationalizes assignments among Task Forces, and receives their reports.

After a Task Force has submitted a final report on all of its mandate area, or on some significant part of it, the Steering Committee reviews the report and transmits it along with the Steering Committee's own recommendations to the Minister. Thus the present, and subsequent formal reports to the Minister from the Network, in particular subject areas, will consist of two parts: the final Task Force Report as the basic reference document; and, a statement representing the views of the Steering Committee.

STEERING COMMITTEE STATEMENT

General Observations

1. The scope of the Task Force's mandate was modified during the course of its deliberations in two ways:

   1.1 Initially, the Task Force concentrated its work on the need for extended treatment beds in Winnipeg, with the expectation that the needs in rural Manitoba would constitute a second phase. Since certain key members of the Task Force are unable to continue to serve, and since the Task Force on Rural Health Services will, in any case, be considering issues related to extended care, the Steering Committee decided to add the need for extended treatment beds in rural Manitoba to the terms of reference of the latter Task Force and to disband the Task Force on Extended Treatment Beds. However, the Task Force on Rural Health Services will defer studies on extended treatment beds until the present report has been considered by the Minister.

   1.2 Although personal care home beds were not included in its original terms of reference the Task Force concluded that the need for one type of long-term bed accommodation could not be studied in isolation from the supply of other types of long-term bed accommodation. In other words, the use of extended treatment beds will be influenced by factors affecting the supply and use of other inpatient accommodation. The Steering Committee concurs with these conclusions.

2. The Task Force followed a method of enquiry and analysis that was consistent with the Network's objective of encouraging wide consultation and input not only from those institutions and agencies directly concerned with the issues but also from those with a general interest in health services. It should be noted that opinion was divided on certain issues even among experts working in related areas of long term care. Occasionally, representatives from a single institution held different views and gave conflicting advice. The Task Force chose, in such cases, to take the position of the Chief Executive Officer as the institutional position. The Steering Committee regards this as a reasonable approach.

3. The Task Force's recommendations are predicated on several important basic assumptions. These include assumptions about population projections, about the desirable ratio of beds to the size of the population being served and about supply of trained personnel. It is of course possible to derive alternative recommendations if the basic assumptions are modified. We believe the assumptions of the Task Force to be a reasonable basis for policy formulation. As more information becomes available, or as circumstances change, the policies and plans should be adjusted to meet the new circumstances. For example, the target number of new personal care home beds that should be constructed may change depending on the effectiveness of continuing care, and other community-based services, or on changes in population projections.

4. It has become apparent to the Steering Committee that the agencies of the Government responsible for health services planning do not have an adequate management information system for monitoring, in a timely, up-to-date fashion, the actual use of facilities as opposed to their presumed or "officially designated" use. The Task Force analysis and recommendations are predicated on the MHSC designation of bed use but hospital officials indicate that these do not reflect actual use.

5. The Task Force's recommendations to increase the numbers of chronic care beds in service and to construct new personal care home beds,if implemented, would require a substantial increase in the resources devoted to long term care. Obviously the pace of development will be dictated by the fiscal capacity of the Province. We believe that vigorous development of the Continuing Care Program and related community-based services can play an important part in moderating the requirement for, and therefore the overall cost of, long term institutional care. Another strategy that merits consideration, but which the Task Force did not study, is the role of the private sector in the provision of living environments that can reduce pressures on long term care institutions.

6. The Interim Report of the Task Force was circulated to a wide variety of interested parties for comment. The responses were referred to the Task Force for review. We are satisfied that the responses were given full consideration, and contributed in a significant way to the changes that were made to the Interim Report.

Recommendations

In the commentary that follows specific reference to the Task Force Report will be made using the following abbreviations: Task Force = TF; recommendation number = R "n"; page number = P "n".

Definitions

The Steering Committee agrees that the use of the term "Extended Treatment Beds" should be discontinued by Provincial authorities and funded facilities. (TF R1 P17) The categorization of "Rehabilitation Beds," "Personal Care Home Beds," and "Chronic Care Beds" proposed by the Task Force is useful and is endorsed by the Steering Committee.

The Steering Committee recommends that the following definitions be implemented as soon as possible. (TF R2 P18)

CHRONIC CARE BEDS are those beds:

required by persons who: 1) show little or no potential for rehabilitation, 2) can no longer be cared for at home or in a personal care home, and 3) require equipment, facilities, specialized professional expertise and treatment and/or continuous physician supervision not provided in a personal care home.

REHABILITATION BEDS are those beds:

a) required by persons, primarily the elderly, who need rehabilitation or treatment which is of a duration of usually 1 to 6 months because their condition is not amenable to intensive short-term therapy or because the period of recovery is projected to take a long time. The units in which these beds are located often include beds which are occupied by individuals undergoing short-term assessment of their health status and/or rehabilitation potential.

b) in the Rehabilitation Hospital or the Rehabilitation Centre for Children required by

persons who need specialized rehabilitation or treatment for complex conditions.

PERSONAL CARE HOME BEDS are those beds:

required by persons, other than those requiring rehabilitation beds or chronic care beds, who can no longer be cared for at home and whom a multi-disciplinary panel judges to be suitable for long term care of a kind now provided in facilities licensed as personal care homes.

Chronic Care Beds

The Task Force has recommended that there be 186 beds designated as Chronic Care Beds and that these be located as follows:

Winnipeg Municipal Hospital	55
Deer Lodge Centre	131

The Task Force believes that this number is supported by current levels of demand, the turnover of patients and the fact that the numbers on the waiting list are relatively small and not increasing. Within the 186 bed total it is recommended that a 40 bed unit for brain damaged persons be established in one of the aforementioned institutions after full consultation with the Winnipeg Municipal Hospital and Deer Lodge Centre. (TF R3,4 P20)

The Task Force also considered an option that would involve three sites for chronic care beds as follows:

Deer Lodge Centre	64
Winnipeg Municipal Hospital	62
Concordia Hospital	60

The Task Force recommended the two site option because of the established skills at the Deer Lodge Centre and the Winnipeg Municipal Hospital. It was concerned, given the shortage of expert staff, locating additional chronic care beds at other hospitals would spread

available expertise too thinly. The Task Force also noted that the three-site option would require new construction when facilities already exist at Deer Lodge Centre.

The Steering Committee however, believes that the three site option is a valid option when one takes other considerations into account. First, the Province has already taken steps to increase the number of specially trained personnel required for chronic care. Second, there is a legitimate concern about over-centralization of resources and the need for adequate back-up facilities and personnel. Third, and perhaps most important, is the possible need for greater numbers of designated rehabilitation beds than the Task Force has recommended (see next section on Rehabilitation Beds). The three site option would allow some of the 90 unopened beds at Deer Lodge to be used for rehabilitation rather than for chronic care.

Accordingly, the Steering Committee, while accepting the Task Force's recommendation with respect to the total number of chronic care beds required, believes that there are two valid options as to the location of these beds (see above) and that the choice between them should be influenced by the projected availability of expert personnel, the desired balance between centralization and decentralization of programs and the need for existing facilities at Deer Lodge Centre and the Winnipeg Municipal Hospital for rehabilitation beds.

The Task Force has recommended that chronic care patients be subject to a panelling process. Respondents to the Interim Report were concerned about proliferation of panelling processes. In its final report the Task Force has made it clear that panelling of chronic care patients would be part of the panelling process of personal care home applicants.

The Steering Committee endorses this recommendation (TF R5 P21) and the accompanying recommendations (TF R6-9 P22,23) dealing with:

- additional resource requirements for the Continuing Care Program in support of the panelling process
- modification by the MHSC of the current Personal Care Home Application and Assessment Form to make it suitable for Chronic Care referral
- the establishment of a computerized management information system to support the panelling and placement system for chronic care patients
- mandatory annual re-assessment of occupants of chronic care beds

Rehabilitation Beds

The Task Force based its assessment of the adequacy of the supply of rehabilitation beds it proposes (372) in relation to the population of persons 65 and older in 1996. The Task Force projects that the ratio of beds to population will fall from 5.1 to 4.2 per 1000 by 1996 but believes that this supply will still be adequate.

It should be emphasized that the figure of 372 rehabilitation beds is a net figure derived by subtracting the numbers of beds in rehabilitation units allocated to patients awaiting placement in personal care homes (PCH-waiting). The current total supply and its distribution and the figures proposed by the Task Force are given in the following Table:

Location	Rehabilitation Beds			
	Total		PCH-waiting	
	Current	Proposed	Current	Proposed
Concordia	0	0	0	0
Deer Lodge	44	67	0	25
Grace	0	0	0	0
HSC	59	59	23	29
Misericordia	34	34	0	11
St. Boniface	184	184	55	55
Seven Oaks	110	110	55	45
Victoria	12	12	0	4
Municipal	195	117	91	42
Total	638	583	224	211
Net Rehab	414	372		

The supply and distribution proposed by the Task Force uses all available, unopened beds at Deer Lodge, provides 4.2 beds per 1000 aged 65 and older in 1996, accords with the recommendations of the geriatricians by proportioning PCH-waiting beds among the rehabilitation units so as not to exceed a maximum of 36% of total rehabilitation complement.

As noted in the previous section on chronic care beds, one of the key issues is whether the proposed supply ratio of 4.2 beds per 1000 is the correct one. The Task Force points out that valid comparative data from other jurisdictions are scarce and their reliability questionable.

The Steering Committee notes that the Task Force's methodology in arriving at the net total requirement i.e., subtracting the PCH-waiting beds from the total number of beds, is based on the assumption that beds designated as PCH-waiting are not in fact occupied by rehabilitation patients. Taken together with the uncertainty about the best planning figure for the bed supply ratio the Steering Committee believes the figure of 372 as the target bed supply ratio may be too low.

The Steering Committee believes that the Task Force recommendation of 372 rehabilitation beds should be regarded, for planning purposes, as the lower limit of a range, with the upper limit being the current bed supply ratio of 5.1 per 1000 applied to the projected 1996 population for persons 65 years and older yielding a figure of 451 beds. The choice of the specific figure within this range should be made after further more detailed analysis of program requirements.

The Steering Committee recommends that any supply requirement above the minimum of 372 beds be met at Deer Lodge Centre and the Winnipeg Municipal Hospital by the use of existing bed facilities. In the case of Deer Lodge Centre, some of the current unopened beds could be used to accommodate rehabilitation patients if the three site option for chronic care beds identified in the previous section were chosen.

The Steering Committee questions the cost-effectiveness and the efficacy of rehabilitation units significantly smaller than 40 beds. The Victoria Hospital unit is anomalous in this respect and it is recommended that the 12 beds at Victoria designated as a rehabilitation unit be used for other purposes.

The Steering Committee endorses the Task Force Recommendation that priority (equal to, but not higher than, that for placements from the community) be given to placing panelled patients occupying rehabilitation beds into personal care homes when the number of such patients reach the maximum PCH-waiting allocation. (TF R11 P28)

The Steering Committee supports the designation of District Rehabilitation Units as recommended by the Task Force and shown below. (TF R12 P29,30)

PROPOSED DISTRICT REHABILITATION UNITS		
District	Assessment/Rehab Units	Associated Institutions
East	St.Boniface Hospital	Concordia Hospital
North	Seven Oaks Hospital	
West	Deer Lodge Centre	Grace Hospital
South	Municipal Hospital	Misericordia Hospital Victoria Hospital
Central	Health Sciences Centre	

The Steering Committee supports the development of district teams drawn from the Rehabilitation Units, the Associated Institutions and the Continuing Care Program to facilitate smooth flow of patients through the rehabilitation beds. Some additional resource will be required to support such teams. (TF R13-15 P31,32)

The Task Force has recommended that up to 20 beds, depending on need, within the 184 bed rehabilitation unit at St. Boniface Hospital be designated for the use of elderly patients from Concordia Hospital. The hospitals have voiced objections to this proposal but the Task Force remains convinced that it represents the most cost-effective use of scarce professional resources. (TF R16 P32) The St. Boniface Hospital has, since the Task Force report was submitted, explicitly rejected the proposition that 20 rehabilitation beds at St. Boniface Hospital be specifically designated for priority use by Concordia Hospital patients. St. Boniface Hospital insists on using only one criterion for accessing beds; namely, the needs of the patient for inpatient rehabilitation services.

The Steering Committee does not believe that any change in the current informal, cooperative arrangements between St. Boniface Hospital and Concordia Hospital are needed at this time.

No new supply of beds is recommended for specialized rehabilitation and treatment of complex cases at the Health Sciences Centre Rehabilitation Hospital since the current supply is comparable to or greater than the supply in other centres. Within the current

supply the establishment of a 13-20 bed unit in the Rehabilitation Hospital for brain damaged patients is recommended.(TF R17,18 P33,34)

> The Steering Committee recognizes that a determination of the total supply and distribution of rehabilitation beds is only one aspect of an effective inpatient rehabilitation system. Of equal and perhaps greater importance is the coordination and interaction of inpatient rehabilitation programs among the various facilities. We understand that some cooperative inter-institutional planning is now underway and urge that this be enhanced and formalized under the aegis of the appropriate government agency.

Personal Care Home Beds

The terms of reference of the Task Force called for recommendations on "changes in policies and procedures in acute care hospitals and personal care homes that would optimize the utilization of extended treatment beds." The Task Force found that it could not develop meaningful advice in this area without undertaking a comprehensive assessment of the supply of personal care home beds and the numbers of acute care hospital beds used for patients awaiting placement in personal care homes.

The Task Force defined the supply of personal care home beds as the number of such beds available per 1000 persons in the population aged 75 years and older. As of June 1988, the bed supply ratio was 140 per 1,000. Since the population aged 75 years and older is projected to increase by 10,970 from 1986 to 1996, an increase of 1,442 beds (from 4,452 to 5,894) would be required to maintain a ratio of 140 per 1,000.

The Task Force considered a variety of permutations and combinations involving manipulation of the following variables: the supply of beds in personal care homes; the number of beds in acute care and rehabilitation units occupied by panelled patients awaiting placement in personal care homes; the personal care home bed supply ratio; and the level of home care services. In choosing the option it wished to recommend the Task Force noted that the current bed supply ratio of 140 per 1000, which is significantly lower than other provincial jurisdictions, is workable only because of the high quality and effectiveness of home care services in Manitoba.

The Task Force opted to recommend that the bed supply ratio be maintained at 140 per 1000 through 1996 by the construction of 1442 additional personal care home beds, by increasing home care and related services to allow as many of the increased number of persons 75 years and older as possible to remain at home, by minimizing transfer delays, by improving rehabilitation and assessment services, and by providing the additional funding necessary to operate an expanded assessment and panelling system.

The Task Force suggests that the construction of additional personal care home beds should be phased in. This would allow other policies, such as significant expansion of home care services, to be implemented with the result that the bed supply requirement might be reduced below the 140 per 1000 figure. A phased approach is also important because demographic projections indicate that the numbers of persons aged 75 years and older will decline somewhat in the period 2000 to 2020 before increasing again. (TF R19,20 P35-43)

The Task Force has responded to the concern about meeting the cultural and religious needs of potential Personal Care Home patients by recommending that the current ri io of "non-secular" to "secular" beds (approximately 44%) be maintained as the system expands. The Steering Committee regards this as a reasonable first approximation. The desirable balance secular and non-secular beds in the future will depend on both demographic and ethno-cultural trends. (TF R21 P43,44; see also TF R31 P50,51)

The Task Force has also recommended that most of the additional beds be for heavy care; that special training be provided in the management of cognitively impaired patients; and, that staffing mix, the physical environment and unit organization be adapted to better meet the needs of patients exhibiting psychogeriatric behavior problems. (TF R22-24 P44-46)

The distribution of the additional beds recommended by the Task Force provides 360 beds in each of three areas identified by MHSC staff as being significantly deficient in such facilities.

DISTRICT	NUMBER OF BEDS
Fort Rouge, River Heights East Tuxedo	360
Elmwood, East and North Kildonan, East St. Paul	360
West End bounded by Sherbrook, Portage, Route 90 and Ass.Rive	360
Planning Reserve	362
TOTAL	1442

Some 362 beds of the proposed total of 1442 would constitute a planning reserve to take emerging needs into account. Of the 360 beds

designated for the Fort Rouge-River Heights-East Tuxedo district, it is recommended that 230 beds be located at the site of the Municipal Hospital because of the availability of scenic land, suitable for a variety of levels of long term care; and because the newly constructed power plant facility can be upgraded, within the original design features, to serve over 400 beds. (TF R26,27 P46-48)

With regard to the number of beds designated for panelled patients in acute care hospitals, the Task Force recommends: that the number of beds designated for panelled patients at Concordia Hospital be reduced as new personal care home beds are constructed in its area; that there be no other change in the total number of such beds in the acute care hospitals; that the MHSC and the Office of Continuing Care revise the distribution of such beds among hospitals to make it more equitable. (TF R28-30 P47-49)

The Task Force has also made specific recommendations with respect to panelled patients in acute care hospitals awaiting placement in personal care homes. These recommendations deal with: mandatory interim placement; placement priorities; and, a public education program on the objectives of the interim placement policy. It should be noted that the numbers of panelled patients in acute care hospitals awaiting placement in personal care homes will depend on the supply of personal care home beds, demands for placement from persons in the community and the efficacy of continuing care and related programs. (TF R31 P50,51)

The Steering Committee endorses recommendations 19-31 dealing with personal care home beds as a reasonable basis for ongoing planning in this sector of health service provision. The Steering Committee suggests that these recommendations be considered in the light of the forthcoming reports from the Task Force on Health Services for the Elderly. They must also be considered in relation to the caveats identified by the Task Force on Extended Treatment Bed Review itself and to the general observations we have made at the beginning of this statement.

The specific quantitative target of 1442 additional personal care home beds can be modified depending on changing conditions; the most important of which is the contribution continuing care and other community based services make towards reducing the dependence on personal care home beds.

In the Committee's view the most important contribution of the Task Force has been in the formulation of a planning framework and in the identification of the key planning parameters. In the end, planning for any social service should respond to some guiding principle. If, in respect of the elderly, the guiding principle is the enabling of elders to remain in their normal home environments as long as possible, then the more this aim is realized the less need there will be for personal care home beds.

Adult Disabled

The Task Force relied on several earlier studies of the problem of both adult and young disabled persons in arriving at its recommendations that: in the development of increased numbers of personal care home beds provision be made to group young disabled adults in appropriate settings; Ten Ten Sinclair act as a transitional facility for brain damaged persons until the need for a new facility can be established; and, that support be provided for the continued development of programs and facilities similar to the FOKUS housing units operated by Ten Ten Sinclair.

The Steering Committee endorses this recommendation.(TF R32-34 P53-57)

Adult Day Care and the Office of Continuing Care

The Task Force has emphasized, at several points in its report, the need to expand community-based programs designed to maintain persons in their own homes as long as possible. Among other things it recommends that: the number of day care program spaces for the elderly be increased in parallel with the growth in the number of persons 75 years and older; the funding of the Continuing Care Program be increased not only in relation to the increasing population of elders but also to allow it to function on a 24-hours-a-day, 7-days-a-week basis.

The Steering Committee endorses the intent of these recommendations but cautions against a misinterpretation of the current situation. For example, there is now 24-hours-a-day, 7-days-a-week care on the basis of assessed need. As the population of elders increases such services should also increase and increased efficiency in dealing with cases requiring such service should be pursued. However, to have such service available "on demand," as it were, is unrealistic and unreasonable.

As noted elsewhere, additional investment in continuing care and related community services may offset some of the requirement for more costly institutional accommodation. As with the need for Personal Care Home Beds the requirement for continuing care and related services will be influenced by a variety of factors including the numbers of elderly in the population which, as noted earlier, is not expected to grow steadily but is projected to decline in the early decades of the next century. (TF R35-37 P58-60)

Special Recommendation

As indicated under general observations, it became evident to the Steering Committee that sound planning for long-term care cannot be

undertaken in the absence of a reliable and accurate management information system. Such a system does not now exist. Actual use of beds and designated use can differ considerably within institutions yet designated use is often the only information readily available.

The Steering Committee recommends that a reliable, accurate and responsive information system be developed for monitoring the actual use of inpatient facilities for long term care, based on the definitions recommended in this report, and for monitoring waiting lists by patient category.

Acknowledgment

The Steering Committee thanks the members of the Task Force, the resource personnel and all those who took the time and trouble to assist the Task Force in its deliberations. In a field as complex as that of health service provision there is no perfect wisdom. Progress comes through the sharing of experience, objective analysis and honest debate. All three attributes have characterized the Extended Treatment Bed Review.